

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 81 04960	
1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <i>Tyne M. Aalto</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>Aug. 18, 1981</i>		2b. HOUR <i>1135 PM</i>			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR <i>Aug. 18, 1902</i>		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		7f. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Finland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		7c. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7d. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil</i>		7e. BALTIMORE CITY OR COUNTY OF DEATH <i>M.D.</i>			
10. CITY OR TOWN OF DEATH <i>Elkton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Union Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>			
13a. STATE <i>Md.</i>		13b. COUNTY <i>Cecil</i>		13c. CITY OR TOWN <i>North East</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>2764 Biggs Highway</i>			
14. FATHER'S NAME FIRST <i>John</i>		MIDDLE <i>Riitaluoma</i>		LAST		15. MOTHER'S MAIDEN NAME FIRST <i>Unknown</i>		MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>219-42-2418</i>		17. INFORMANT <i>Werner Aalto</i>		ADDRESS <i>North East, Md.</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>ISCHEMIC BOWEL DISEASE</i> 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>PROBABLE EMBOLISM</i> { DUE TO, OR AS A CONSEQUENCE OF (c) <i>ACUTE MYOCARDIAL INFARCTION</i> DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>Aug. 22, 1981</i> , to <i>Aug. 20, 1981</i> , that (I) (we) last saw the deceased alive on <i>Aug. 19, 1981</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Ehsanur Rahman</i>		DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>2/11/81</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>EHSANUR RAHMAN</i>		22e. ADDRESS <i>Newark Del.</i>									
23a. BURIAL CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 2-13-81		23c. NAME OF CEMETERY OR CREMATORIAL Cratin & Ferris		23d. LOCATION CITY OR TOWN West Chester		COUNTY STATE Chester Pa.			
24. FUNERAL DIRECTOR NAME <i>Paul R. Conch</i>		ADDRESS North East, Md.		25a. DATE REC'D. BY REGISTRAR FEB 17 1981		25b. REGISTRAR'S SIGNATURE <i>George Morrison</i>					



SEARCHED INDEXED SERIALIZED FILED

RECORDED & SERIALIZED

ACUTE INFLAMMATION OF MAMMARY

10/11/68

X

AM

Wm. H. Miller

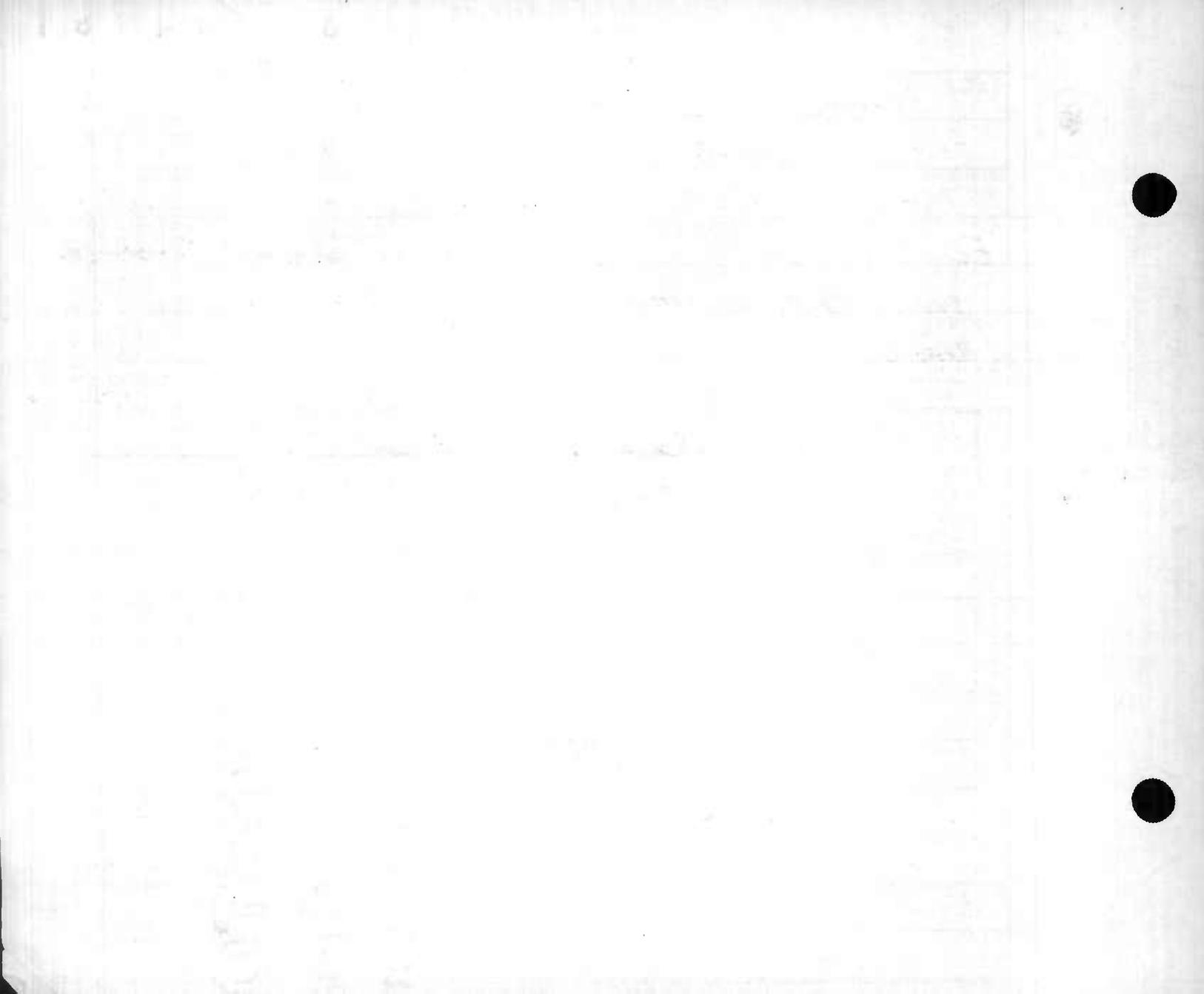
MANHATTAN POLICE

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8104961		
												REG. NO.		
1 - STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20 DATE OF DEATH	MONTH	DAY	YEAR	21 HOUR	
			MABEL			Claire	C. ALLWOOD.	2/6/81					11:05 AM	
3 SEX		4 RACE		5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
FEMALE.		CAUCASION.		MONTH	DAY	YEAR	93	YRS	MONTHS	DAYS	HOURS	MIN		
5. MONTH 5/26		YEAR 1887												
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
OHIO		USA.					Cecil County MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
ELKTON		LAURELWOOD NURSING Center			Cook			Restaurants						
13a. STATE MD.		13b. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 1908 JEFFERSON RD.			21222				
Dundalk														
14. FATHER'S NAME NOBLE		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME MARY			FIRST	MIDDLE	LAST			VERITY.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS 1908 JEFFERSON RD. BALTIMORE, MD 21222			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No		374-14-0678		EVA GRIMES										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> 4380 DUE TO, OR AS A CONSEQUENCE OF (b) <u>C.H.F. Uncontrolled AF</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first (c) <u>Sensitivity</u>														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
					<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>4/3</u> , 19 <u>78</u> , to <u>2/6</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>1/27</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE 		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 2-8-81						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Hyung W. Oh, M.D.		22e. ADDRESS 123 W. High St. Elkton, Md 21921												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/9/1981		23c. NAME OF CEMETERY OR CREMATORIAL Oak Lawn Cemetery			23d. LOCATION CITY OR TOWN Baltimore			COUNTY		STATE Maryland		
24 FUNERAL DIRECTOR NAME Walter Brooks Bradley Inc., Dundalk Md 21222		ADDRESS			25a. DATE REC'D. BY REGISTRAR FEB 9 1981			25b. REGISTRAR'S SIGNATURE 						

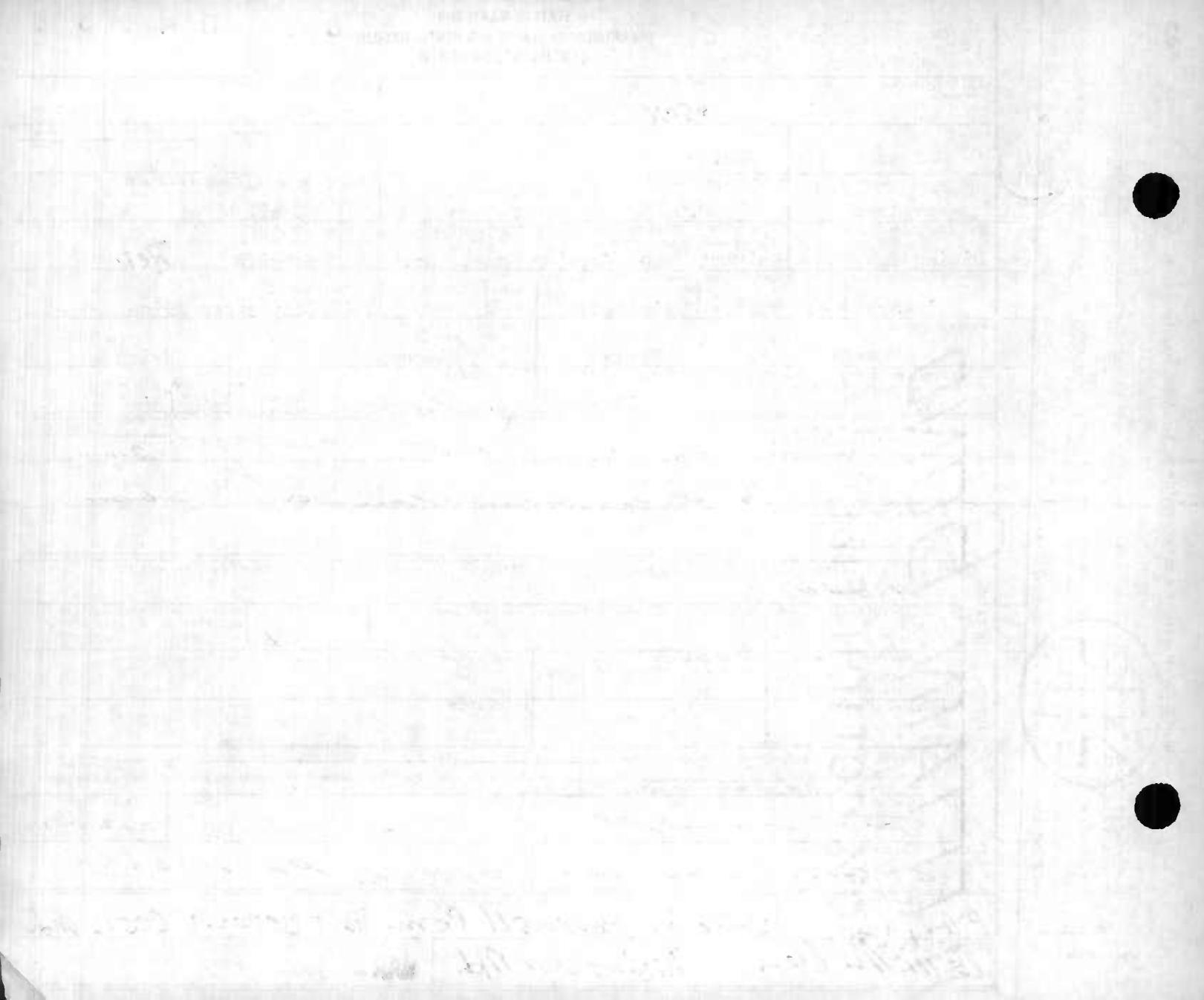


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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8104962
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									REG. NO.
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2b. HOUR						
Pearl Tyson Astle						2-23-81			1:05 PM			
3. SEX Female			4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR 3-9-1899			6. AGE (IN YEARS LAST BIRTHDAY) 81			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.			
10. CITY OR TOWN OF DEATH Rising Sun			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Manor Nursing Home, Inc.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Ret.			
13a. STATE Delaware			13b. COUNTY New Castle	13c. CITY OR TOWN Wilmington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 2613 Stephenson Drive				
14. FATHER'S NAME FIRST MIDDLE LAST George E. Tyson			15. MOTHER'S MAIDEN NAME Sidney			16. SOCIAL SECURITY NO. 159-50-9604			17. INFORMANT ADDRESS Mrs. Evelyn Kowal, 2613 Stephenson Drive Wilm, Del. 19808			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1590</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Sedentary</u> cause DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 m.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>As above</u>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Dr. J. T. Holloman</u>			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 2-23-81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. T. Holloman MD			22e. ADDRESS Oxford, Pa. 15305									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9-26-81			23c. NAME OF CEMETERY OR CREMATORIAL Hippewell Cem. Part Deposit. Cecil Md.			23d. LOCATION CITY OR TOWN COUNTR			
24. MEDICAL DIRECTOR NAME John Muller			25a. ADDRESS Rising Sun Md.			25a. DATE REC'D. BY REGISTRAR MAR 2 1981			25b. REGISTRAR'S SIGNATURE John Muller			



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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8104963				
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Mary					Benner	2-23-81						2:15P M		
3. SEX			4. RACE			5. DATE OF BIRTH			MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)		
Female			White			July 19, 1887						93		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
Lancaster Co., PA			U.S.										YRS	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Rising Sun			Calvert Manor Nursing Home, Inc.			Teacher			School					
13a. STATE PA			13c. CITY OR TOWN East Earl			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS R.D. #1					
14. FATHER'S NAME FIRST Nathaniel			MIDDLE Styer			15. MOTHER'S MAIDEN NAME FIRST Lydia			MIDDLE LAST Glass					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS					
no			193-36-3225			Warren F. Benner, P.O. Box 144, Rising Sun			Maryland 21911, Rising Sun					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first										2 months				
(b) <i>cardiac compensation</i> <i>arteriosclerotic cardiovascular disease</i>										6 yrs.				
(c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 8-15, 1981, to 2-23, 1981, that (I) (we) last saw the deceased alive on 2-23, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Neil Taylor MD										DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 2-23-81
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Neil Taylor MD			22e. ADDRESS Rising Sun, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2/26/81			23c. NAME OF CEMETERY OR CREMATORIAL Cemetery			23d. LOCATION City or Town Burton Lane Rd.			COUNTY	STATE	
24. FUNERAL DIRECTOR Wm. E. Johnson 8521 Loch Raven Blvd.						Towson, Md.			25a. DATE REC'D. BY REGISTRAR MAR 2, 1981			25b. REGISTRAR'S SIGNATURE John J. Murphy		
DHMH - 16 50M 1/76 (VR A 15(4))														

M

1898 - 81290

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												REG. NO.			
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
<i>Rebecca Anna</i>			<i>Bush.</i>						<i>Feb 1 81</i>			<i>7:45 PM</i>			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		White		March 15, 1895			85			MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Pennsylvania		USA					Cecil								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Elkton		Union Hospital						Housewife							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS						
Maryland		Cecil		Elkton					1234 Old Field Point Road						
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST													
Andrew		Chonko													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS							
No		186-10-9566			Mrs. Theresa Parlier, Elkton, Maryland										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Congestive heart failure</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>			
4140 (b) <i>Arterio-sclerotic heart disease</i>															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c)															
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arterio-sclerotic heart disease</i>															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) <i>Perforated Gastric ulcer</i>															
19a. DATE OF OPERATION <i>1/23/81</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Gastric Perforation</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>1/23 1981</i> to <i>2/1 1981</i> , that (I) <input type="checkbox"/> lost saw the deceased alive on <i>2/1 1981</i> , and that in my <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did <input type="checkbox"/> did not view the body after death.															
22b. SIGNATURE <i>John A. Fischer, M.D.</i>												22c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John A. Fischer</i>		22e. ADDRESS <i>166 W MAIN ST., ELKTON, MD</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/5/81			23c. NAME OF CEMETERY OR CREMATORIAL Assumption B.V.M.			23d. LOCATION CITY OR TOWN Mahanoy City, Penna.			COUNTY		STATE		
24. FUNERAL DIRECTOR NAME <i>Ralph E. Sticker</i>		ADDRESS			25a. DATE REC'D. BY REGISTRAR FEB 9 1981			25b. REGISTRAR'S SIGNATURE <i>Henry McCreary</i>							
HICKS HOME for FUNERALS, ELKTON, MD.															

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.					
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR					
I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	February 19, 1981							10:00 PM		
George J C COOPER															
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
Male			White		2 22 1915			65				YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				MD.			
MD			USA					Cecil County							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
Perry Point			VA MEDICAL CENTER							Disabled WW II				Veteran	
13a. STATE MD			13b. COUNTY Baltimore		13c. CITY OR TOWN Pikesville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 20 Hawthorne Ave.					
14. FATHER'S NAME FIRST Charles			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST Josephine			MIDDLE	LAST Wise						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			(IF YES, GIVE WAR OR OATES) WW II		16b. SOCIAL SECURITY NO. 218-05-0431			17. INFORMANT Mr. William J. Krysiak 20 Hawthorne Ave., Baltimore, MD 21208				ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Arrest												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
(b) Carcinoma of Lung DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from Feb. 9, 1981, to Feb. 19, 1981, that (I) (we) lost saw the deceased alive on, Feb. 19, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 2/19/81			
22b. SIGNATURE <i>for Joseph J. Kim</i>			22c. DEGREE M.D.			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input checked="" type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph J. Kim MD			22e. ADDRESS VA MEDICAL CENTER PERRY POINT, MD.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2/24/81			23c. NAME OF CEMETERY OR CREMATORIAL Lake View Memorial Pk.			23d. LOCATION CITY OR TOWN Sykesville Carroll			COUNTY	STATE MD		
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors 8728 Liberty Rd. Randallstown, MD 21133									25a. DATE REC'D. BY REGISTRAR FEB 23 1981			25b. REGISTRAR'S SIGNATURE <i>Loring Byers</i>			

1801, 1802, 1803, 1804, 1805, 1806, 1807

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1812 - 1813

Quando passarão a varzea

Caracteres de Pura

1814, 1815, 1816, 1817, 1818, 1819, 1820, 1821, 1822

1823, 1824, 1825, 1826, 1827, 1828, 1829, 1830, 1831, 1832

1833, 1834, 1835, 1836, 1837, 1838, 1839, 1840, 1841, 1842

1843, 1844, 1845, 1846, 1847, 1848, 1849, 1850, 1851, 1852

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	8104966	
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR	
1. DECEASED NAME (TYPE OR PRINT)			February 6, 1981			823 A.M.	
Annie Elizabeth Cullen							
3 SEX		4 RACE	5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		
Female		White	August 21m1891		89		
7a BIRTHPLACE COUNTRY		7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Cecil		
Maryland		U.S.A.			MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Rising Sun		392 Biggs Highway			Housewife		
13a STATE Maryland		13b COUNTY Cecil	13c CITY OR TOWN Rising Sun	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 392 Biggs Highway	
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		LAST	
William		Edward	Owens	Hannah		Sentman	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT		ADDRESS	
No		220-34-7028		Jean Lucas		same as above	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) general arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Cerebrovascular accident 2 wks. 5 yrs.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET		CITY OR TOWN	COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 8-5 19 28 to 2-6 19 81, that (I) (we) lost saw the deceased alive on 2-5 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Neil Taylor Jr MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 2-7-81
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS Rising Sun, Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Feb. 9, 1981	23c. NAME OF CEMETERY OR CREMATORIAL West Nottingham Cemetery Colona Cecil Maryland		23d. LOCATION CITY OR TOWN		23e. COUNTY STATE
Burial							
24. FUNERAL DIRECTOR NAME		ADDRESS Rising Sun, Maryland		25a. DATE REC'D. BY REGISTRAR FEB 10 1981		25b. REGISTRAR'S SIGNATURE	
John H. Miller							

TO HOSPITAL OR ATTENDING PHYSICIAN: The physician retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the physician or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, ~~Page 3~~,
should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours at a time
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Name 21 is marked on Item 18 above, no injury, or other traumatic event, the medical examiner must be notified ~~as soon as~~.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 4 9 6 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
CLETUS J. DEAN						February 15, 1981				9:45P M	
3. SEX	4. RACE	5. DATE OF BIRTH	MONTH	DAY	YEAR	6. AGE IN YEARS LAST BIRTHDAY	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	HOURS	MIN.	
Male	White	3-9-1922				58					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8.	MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH				
Virginia	USA						Cecil County MD				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					
Perryville	VA Medical Center, Perry Point, Md					Carpenter					
13a. STATE THE COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET ADDRESS				
PA Chester	Oxford						Box 219				
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME					FIRST	MIDDLE	LAST
John A. Dean				Clara McDaniel							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.		17. INFORMANT					ADDRESS			
Yes	WTF		Irene Dean Box 219 Oxford Pa 19363								
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY											
IMMEDIATE CAUSE (a) Acute Myocardial Infarction											
4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED {ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2}		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from February 15, 1981, to February 15, 1981.											
22b. SIGNATURE DEGREE niranjan Shah MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS VA Medical Center, Perry Point, Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIUM					23d. LOCATION CITY OR TOWN			
Burial		2/19/81	Oxford Cemetery					Oxford Chester PA			
24. FUNERAL DIRECTOR NAME		24b. ADDRESS			24c. DATE REC'D. BY REGISTRAR					25b. REGISTRAR'S SIGNATURE	
Ralph m Reed		Board Funeral Home, Rising Sun Md			FEB 24 1981					Linda	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of after death. Page 4 may be reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 0 4 9 6 8			
										REG. NO.			
1 - FOR STATE REGISTRAR			FIRST MIDDLE LAST			2a. DATE OF DEATH February 12, 1981			MONTH YEAR		2b. HOUR 4:40 PM		
1. DECEASED NAME (TYPE OR PRINT)			ARTHUR DONOVAN			5. DATE OF BIRTH MONTH DAY YEAR May 20, 1928			6. AGE (IN YEARS LAST BIRTHDAY) 52		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
3. SEX Male			4. RACE White			7. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.		
10. CITY OR TOWN OF DEATH Perryville			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center Perry Point, Md.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Stock Clerk			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Del.			13b. COUNTY New Castle			13c. CITY OR TOWN Wilmington			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 617 7th Avenue		
14. FATHER'S NAME FIRST William			MIDDLE Donovan			15. MOTHER'S MAIDEN NAME FIRST Anna			MIDDLE		LAST Webb		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. Korean 222-16-1502			17. INFORMANT X Lavina Donovan 617 7th Ave.			ADDRESS Wilmington, Del.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease { DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12-22 , 19 80 , to 2-12 , 19 81 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 2-12 , 19 81 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (I <input checked="" type="checkbox"/> did) <input type="checkbox"/> view the body after death.										22c. DATE SIGNED 2-12-81			
22b. SIGNATURE Stanley I. Phillips			22c. DEGREE M.D.			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STANLEY I. PHILLIPS, M.D.			22e. ADDRESS VAMC Perry Point, Md.			23d. LOCATION CITY OR TOWN Newark, New Castle, Del.			23e. COUNTY STATE				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2/17/81			23c. NAME OF CEMETERY OR CREMATORIAL Newark Cem.			23d. LOCATION CITY OR TOWN Newark, New Castle, Del.				
24. FUNERAL DIRECTOR NAME Robert T. Jones			DRESS			25a. DATE REC'D. BY REGISTRAR FEB 23 1981			25b. REGISTRAR'S SIGNATURE Robert T. Jones				
R. T. JONES FUNERAL HOME, Newark, DE													

1991-10-15, 1991

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TO HOSPITAL OR ATTENDING PHYSICIAN: The physician retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 1 0 4 9 6 9				
										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST CARL	MIDDLE W.	LAST EATON	SR	2a. DATE OF DEATH February 20, 1981	MONTH YEAR	DAY	YEAR	2b. HOUR 2:15pm	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH Sept. 24, DAY 1917 YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maine		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County				MD.	
10. CITY OR TOWN OF DEATH Perry Point		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Store Clerk		12b. KIND OF BUSINESS OR INDUSTRY Buckworth Market					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland	13b. COUNTY Cecil	13c. CITY OR TOWN Port Deposit		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 21 Abrahams Rd., Port Deposit, Md.					
14. FATHER'S NAME FIRST Kenneth		MIDDLE 	LAST Eaton	15. MOTHER'S MAIDEN NAME FIRST Elsie		MIDDLE 	LAST Yerkes				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. W.W. II 220-01-5928		17. INFORMANT		ADDRESS 21 Abrahams Road, Lawrence D.Eaton, Sr. Port Deposit, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4850 Cardiorespiratory arrest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) Septic shock											
DUE TO, OR AS A CONSEQUENCE OF (c) Bilateral extensive bronchopneumonia											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from February 16, 1979 , to February 20, 1981 , XXXXXX , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Julian Ocejo, M.D.		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 2-20-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JULIAN OCEJO, M.D.		22e. ADDRESS VAMC, Perry Point, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 24, 1981		23c. NAME OF CEMETERY OR CREMATORIAL West Nottingham Cem.		23d. LOCATION CITY OR TOWN Colora		CITY OR TOWN Cecil		COUNTY STATE Maryland	
24. FUNERAL DIRECTOR See PATTERSON FUNERAL HOMES		ADDRESS Perryville, MD		25a. DATE REC'D. BY REGISTRAR FEB 26 1981		25b. REGISTRAR'S SIGNATURE Henry McElroy					

1970-1971
1971-1972

BIGELOW

1972-1973

1973-1974

1974-1975

1975-1976

1976-1977

1977-1978

1978-1979

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8104970	
										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>James</i>	MIDDLE <i>W.</i>	LAST <i>Farmer</i>	2a. DATE OF DEATH <i>Feb. 20, 1981</i>	MONTH <i>Feb.</i>	DAY <i>20</i>	YEAR <i>1981</i>	2b. HOUR <i>1051A</i>	
3. SEX <i>Male</i>		4 RACE <i>White</i>	5 DATE OF BIRTH <i>Month Jan 8, 1927 Day Year</i>			6 AGE (IN YEARS LAST BIRTHDAY) <i>54</i>		IF UNDER 1 YEAR MONTHS <i>54</i>		IF UNDER 24 HRS MONTHS DAYS HOURS MIN <i>YRS</i>	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>W. Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil</i>				
10. CITY OR TOWN OF DEATH <i>Elkton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Union Hospital</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Motorman</i>				12b. KIND OF BUSINESS OR INDUSTRY <i>Mining</i>		
13a. STATE <i>Md.</i>		13b. COUNTY <i>Cecil</i>		13c. CITY OR TOWN <i>Elkton</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>P. O. Box 913</i>			
14. FATHER'S NAME FIRST <i>George</i>		MIDDLE <i>Allen</i>	LAST <i>Farmer</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Myrtle</i>		MIDDLE <i>Graham</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>235-34-8875</i>			17. INFORMANT <i>Ethel B. Farmer P. O. Box 913 Elkton, Md.</i>		ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
18. CAUSE OF DEATH (Enter only one cause per line for 1(a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Respiratory Arrest. due to anoxia</i>											
57/2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Bran damage due to cardiopulm, arrest</i> (c) <i>Alcoholism, pulmonary edema due to alcohol intoxication</i>											
DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Chronics of Liver.</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>8/22</i> , 19 <i>78</i> , to <i>2/20</i> , 19 <i>81</i> , that (I) (we) last saw the deceased alive on <i>2/20</i> , 19 <i>81</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Anne Hsu, MD</i>		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED <i>Feb. 20, 1981</i>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Jui chih Hsu</i>		22f. ADDRESS <i>223 West Main St. Cecil, Md 21921</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>2-23-81</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Horsepen Cemetery</i>			23d. LOCATION CITY OR TOWN <i>Horsepen</i>		COUNTY <i>Tazewell</i>	STATE <i>Va.</i>	
24. FUNERAL DIRECTOR NAME <i>EE Funeral Home P.A.</i>		25a. DATE REC'D. BY REGISTRAR ADDRESS <i>Elkton, Md.</i>			25b. REGISTRAR'S SIGNATURE <i>Victor Kelley</i>						

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TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death, unless Page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be retained by the hospital or attending physician.

MEDICAL CERTIFICATION

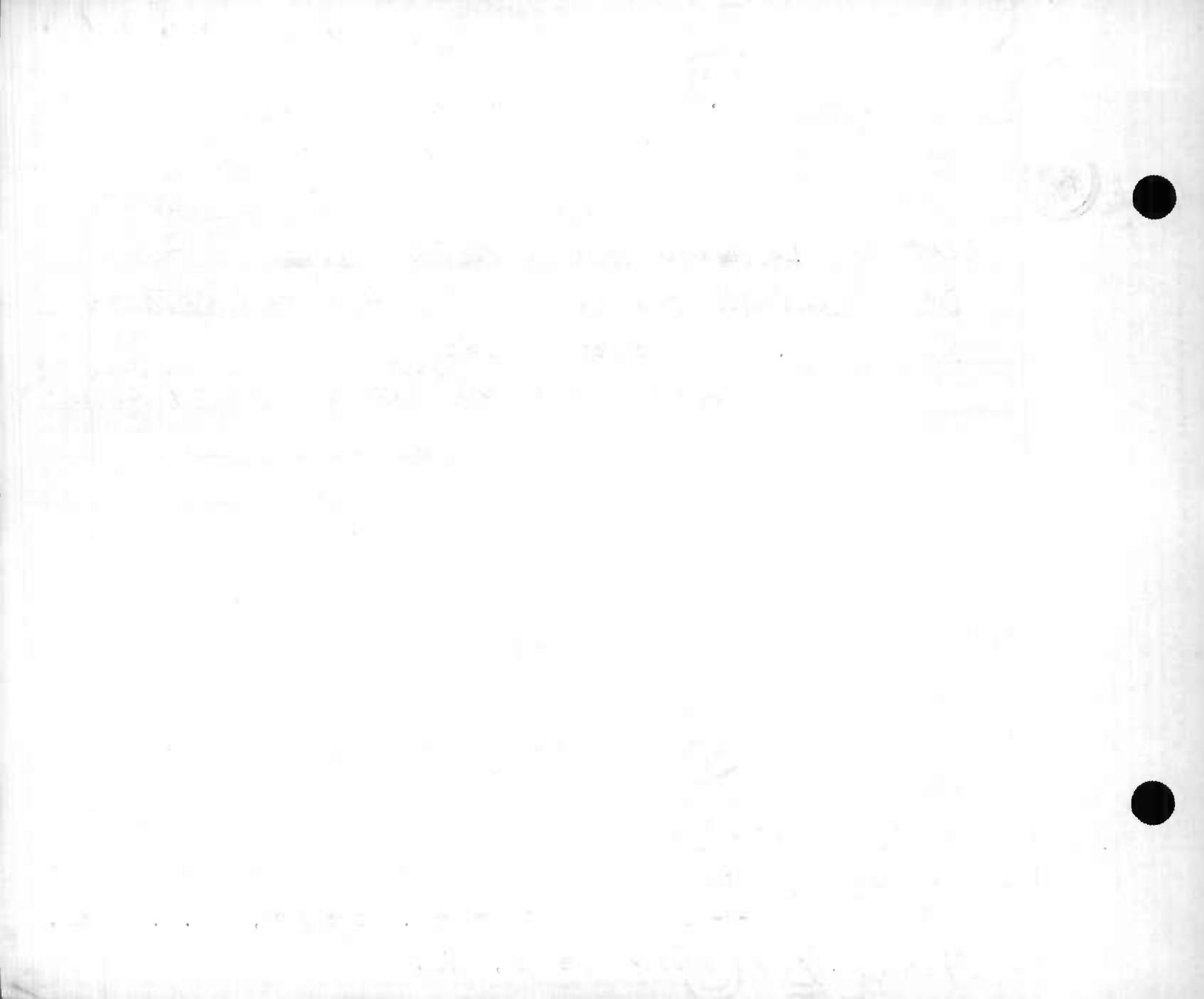
1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

81 04971

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2e. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
<i>RAYMOND F. FORAKER</i>						<i>2/28/81</i>				<i>1230 P.M.</i>		
3. SEX		4 RACE	5 DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
<i>M.</i>		<i>Caucasian</i>	MONTH	DAY	YEAR	<i>81</i>	YEARS	MONTHS	DAYS	IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			
<i>PA.</i>		<i>USA</i>				<i>Cecil County</i>			<i>ELKTON</i>			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
<i>Lakewood Nursing Center</i>			<i>Foreman</i>			<i>Budd Co.</i>						
13a. STATE			13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
<i>De</i>			<i>New Castle</i>	<i>Newark</i>		YES <input type="checkbox"/>	NO <input type="checkbox"/>	<i>9 South Kingston Rd.</i>				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
FIRST <i>John</i>			MIDDLE <i>C.</i>	LAST <i>Foraker</i>			FIRST <i>Keith</i>			MIDDLE	LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO			17. INFORMANT (SON)			ADDRESS			
(If Yes, Give War or Dates) <i>1539</i>			<i>221-07-8095</i>			<i>RAYMOND FORAKER</i>			<i>NEWARK, DE 9 South Kingston Rd.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <i>Aspiration - pneumonia</i>												
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any			(b) <i>Stroke syndrome with coma</i>									
{ DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cancer of liver & debility</i>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>1/17</i> , 19 <i>79</i> , to <i>2/24</i> , 19 <i>81</i> , that (I) (we) last saw the deceased alive on <i>2/24</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>James R Dearworth, M.D.</i>		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>2/28/81</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>McLean and Dearworth</i>		22e. ADDRESS <i>167 W. Main St. Newark Del. 19711</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>3-3-81</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Hickory Grove Cem.</i>		23d. LOCATION CITY OR TOWN <i>St Georges, N.C.</i>		STATE <i>Dela.</i>	25a. DATE REC'D. BY REGISTRAR			
24. FUNERAL DIRECTOR <i>William J. Warwick</i>		ADDRESS <i>Newark, Dela.</i>		25b. REGISTRAR'S SIGNATURE <i>Henry DeBrady</i>		MAR 3 1981						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use as the burial/transit parent. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or either traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) Vera Rose Haley				2. DATE OF DEATH FEB 28 1981				2b. HOUR 6 P		
3. SEX female		4 RACE caucasian		5. DATE OF BIRTH MONTH 09 DAY 21 YEAR 30		6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN 0		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil		MD.				
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital of Cecil County				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plastics worker		12b. KIND OF BUSINESS OR INDUSTRY Plastic				
13a. STATE Del		13b. COUNTY New Castle		13c. CITY OR TOWN Middletown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RD #2				
14. FATHER'S NAME FIRST Charles MIDDLE R LAST Price		15. MOTHER'S MAIDEN NAME FIRST Bertha MIDDLE Hopkins										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO 217-28-2735		17. INFORMANT Husband Hilding A Haley - Middletown, Del.		ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 22 MONTHS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: Pancreatic Carcinoma.												
IMMEDIATE CAUSE (a) 1579 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												
DUE TO, OR AS A CONSEQUENCE OF (b) _____												
DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION December 80		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of the Pancreas				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET 211 CITY OR TOWN Cecilton, Md. COUNTY 21913 STATE Del.								
22a. I certify that (I) (we) attended the deceased from 5-21-79 to 2-28-81 , that (I) (we) last saw the deceased alive on 2-28-81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.												
22b. SIGNATURE Wallace Openshaw, M.D. DEGREE M.D.												
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> 22c. DATE SIGNED 3-3-81												
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wallace Openshaw, M.D.		22e. ADDRESS Cecilton, Md. 21913										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar 4, 1981		23c. NAME OF CEMETERY OR CREMATORIUM Towson Crem.		23d. LOCATION CITY/TOWNSHIP Towson-T.O.C. Del. COUNTY Del.						
24. FUNERAL DIRECTOR NAME Robert C. Hatchison - Middletown, Del.		25a. DATE REC'D. BY REGISTRAR MAR 11 1981				25b. REGISTRAR'S SIGNATURE Robert C. Hatchison						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8104973			
1 - FOR STATE REGISTRAR					REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR		
Ruth A. Hopkins					Feb 26 1981	12 PM		
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)			
Female		Caucasian	80	7	03	77 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland		Us				Cecil		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Calvert MD		Calvert manor Nsy Home				12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland		13b. COUNTY Cecil	13c. CITY OR TOWN Port Deposit	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 23 S. Main St		
14. FATHER'S NAME FIRST William		MIDDLE	LAST McCurrough	15. MOTHER'S MAIDEN NAME FIRST Lavina		MIDDLE	LAST Crouch	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. No		17. INFORMANT 215-32-0908		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4860 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia 6 days		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 2-15 1980 to 2-25 1981, that (I) (we) last saw the deceased alive on 2-25 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Neil Taylor		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 2-27-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Neil Taylor MD		22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MAR 1, 81		23c. NAME OF CEMETERY OR CREMATORIAL BAKER'S CEM.		23d. LOCATION CITY OR TOWN ABERFOEEN, HARFORD, MD		STATE
24. FUNERAL DIRECTOR Matthew J. H. Mitchell		ADDRESS Havre de Grace MD		25a. DATE REC'D. BY REGISTRAR MAR 1, 81		25b. REGISTRAR'S SIGNATURE		

BURIAL MAR 1 '81 PAKERS GENE ABEDOEEN MARYFORD WA

SAME

Rev. George H. Kuhn

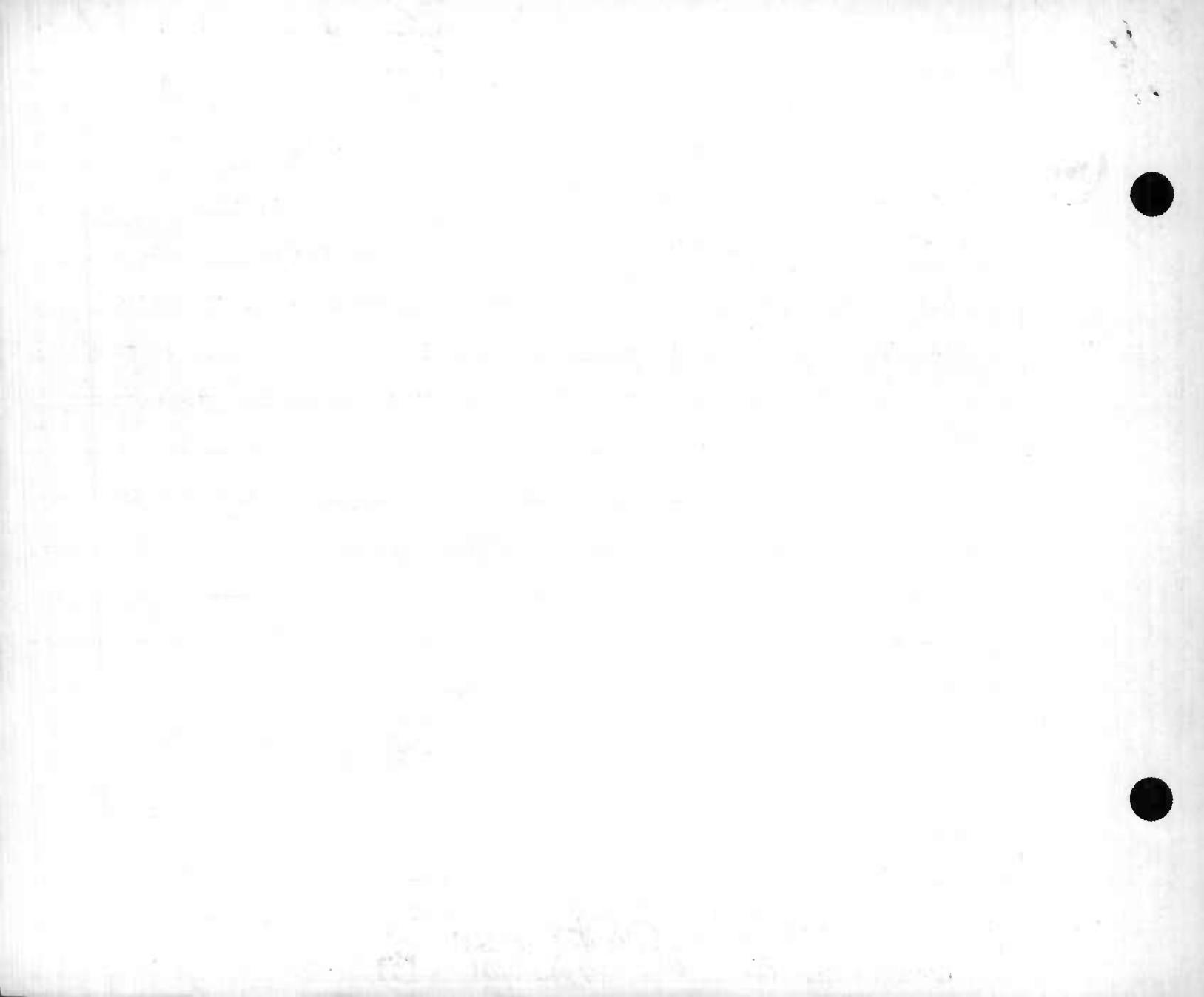
WIA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 0 4 9 7 4				
										REG. NO.				
1 - STATE REGISTRAR			Y DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
			ARTHUR C.			HOPKINS			2-9-81			9:45 AM		
3. SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
M		Cauc.		11 25 89			91 XXX			YRS.		MONTHS DAYS HOURS MIN		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
ENGLAND		England xxxx						CECIL						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
ELKTON		LAURELWOOD NRING			BUTLER			Private Homes						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		10410 FAWEETT STREET				
Md.		Montgomery		KENSINGTON										
14. FATHER'S NAME		FIRST <u>Henry</u>	MIDDLE <u>XXXXXX</u>	LAST <u>HOPKINS</u>	15. MOTHER'S MAIDEN NAME		FIRST <u>ANNE</u>	MIDDLE	LAST <u>BUTLIN</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		16c. INFORMANT		(son)		ADDRESS		(same as 13e)				
NO		036 22 9255A		HENRY Hopkins										
18. CAUSE OF DEATH (Enter only one cause per line for 10), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
<u>4860</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										<u>Cardiogulmonary arrest</u>				
DUE TO, OR AS A CONSEQUENCE OF (b) <u>pneumonia</u> . <u>Congestive heart failure</u> .														
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Sen: 1st</u>														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
		P.M. 19												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 ____ to _____, 19 _____. That (I) (we) last saw the deceased alive on 2-9-81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <u>Hyung W. Oh, M.D.</u>										DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 2-9-81
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Hyung W. Oh, M.D.</u>										22e. ADDRESS <u>123 W. High St. Elkton, Md. 21921</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 2-12-1981		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS National Memorial			23d. LOCATION CITY OR TOWN Falls Church		CITY OR TOWN Falls Church		COUNTY		STATE	
24. MEDICAL DIRECTOR 8434 Ga. Ave. <u>Pumphrey, Inc.</u>		24b. ADDRESS <u>Clarks Way</u>		24c. DATE REC'D. BY REGISTRAR <u>FEB 17 1981</u>			25b. REGISTRAR'S SIGNATURE <u>Troy McElroy</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8104975										
												REG. NO.										
1 - FOR STATE REGISTRAR			FIRST			MIDDLE			LAST			20. DATE OF DEATH	MONTH	DAY	YEAR	26 HOUR						
1. DECEASED NAME (TYPE OR PRINT)			John			W			Jones			February 4, 1981					6:30P M					
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR May 30, 1924			6. AGE (IN YEARS LAST BIRTHDAY) 56			IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS DAYS		HOURS MIN						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County			10. CITY OR TOWN OF DEATH Perryville										
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center, Perry Point, Md			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seaman			12b. KIND OF BUSINESS OR INDUSTRY Merchant Marine			13a. STATE Maryland					13b. COUNTY City		13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 16 S. Broadway	
14. FATHER'S NAME FIRST William			MIDDLE J.			LAST Jones			15. MOTHER'S MAIDEN NAME FIRST Esther			MIDDLE M.		LAST Williams								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII			16c. SOCIAL SECURITY NO. 184-120334			17. INFORMANT Mrs Reva Jarrett, 1908 Billy Barton Cir.			ADDRESS										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Larynx with Metastases</u>												APPROXIMATE TIME INTERVAL BETWEEN ONSET AND DEATH										
1619 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost { b) DUE TO, OR AS A CONSEQUENCE OF c) DUE TO, OR AS A CONSEQUENCE OF																						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																						
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE									
22a. I certify that (I) (this hospital) attended the deceased from September 12, 1980, to February 4, 1981. XXXXXXXXX																						
22b. SIGNATURE <u>Louise Sultan</u>												22c. DEGREE										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>To</u> <u>Louise Sultan</u>												ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> 2-4-81										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 2-7-81			23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Crematory			23d. LOCATION CITY OR TOWN Baltimore, Maryland													
24 FUNERAL DIRECTOR NAME Ruck Funeral Home, 1050 York Road, Towson, Md			ADDRESS			25a. DATE REC'D. BY REGISTRAR FEB 11 1981			25b. REGISTRAR'S SIGNATURE <u>R. J. Murphy</u>													

A M A N D A L I C O N T R A H E C T O R Y P O L I G O N U

mento de la actividad económica.

1981-1984 B. 1980, best 1980, 1981, 1982, 1983, 1984

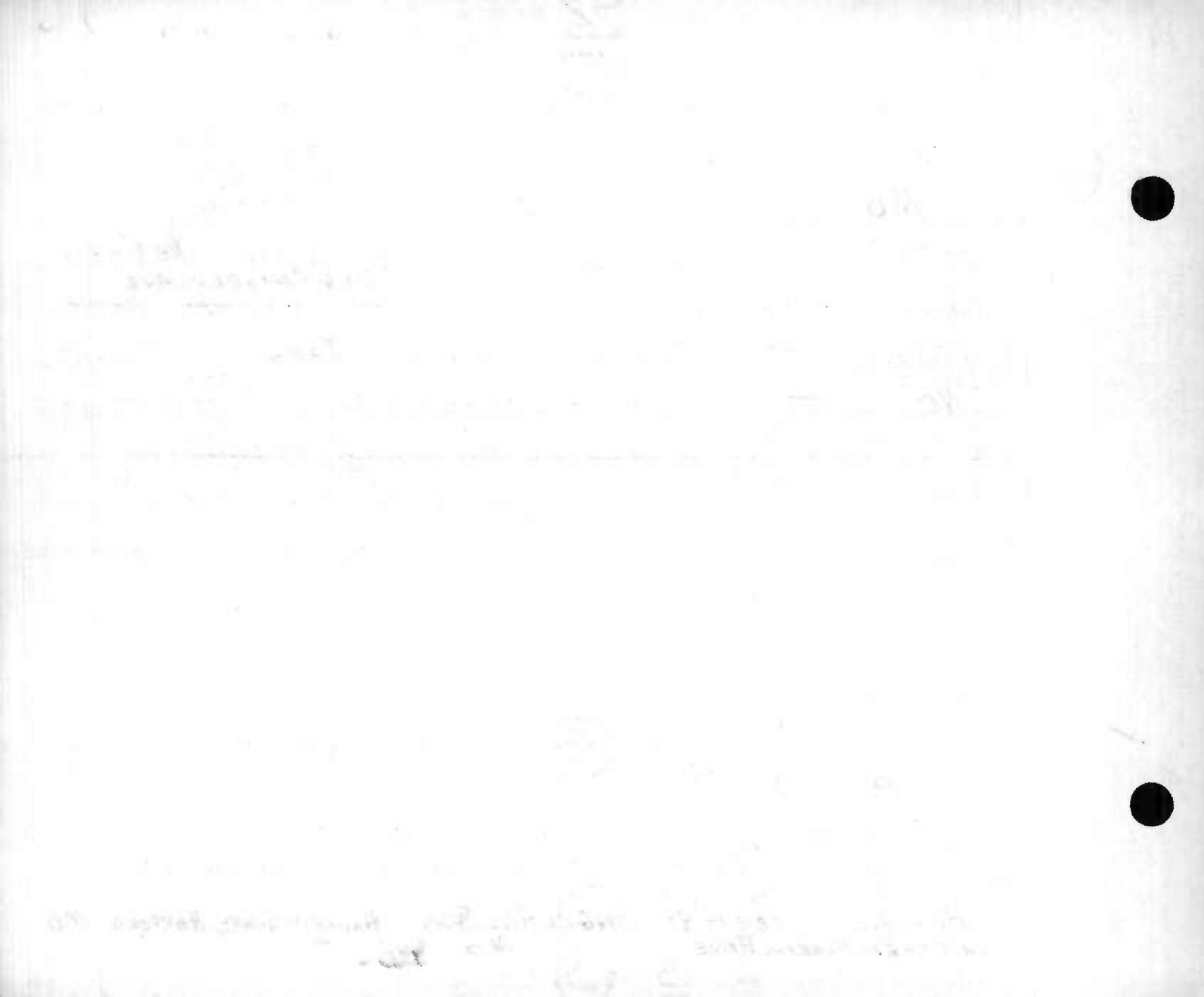
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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 0 4 9 7 6			
										REG. NO.			
1 - FOR STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			Robert A. JONES						2 - 11 - 81			6:45 PM	
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6 AGE IN YEARS LAST BIRTHDAY			IF UNDER 1 YEAR		IF UNDER 24 HRS	
M		CAUC.		7 29 07			73 YRS			MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			
MD		USA					CECIL			ELKTON			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
HAIRWOOD				APC GOVERN.				RETIRED					
13a. STATE Md.				13b. COUNTY Harford		13c. CITY OR TOWN HAIRWOOD		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 441 Chesapeake Dr.			
14. FATHER'S NAME LEONARD				LAST		15. MOTHER'S MAIDEN NAME JONES		16. SOCIAL SECURITY NO. 217-03-1170		17. INFORMANT CHARLOTTE Gibson		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				18b. SOCIAL SECURITY NO. —		18c. ADDRESS HAIRE De GRACE		18d. ADDRESS 991 Chesapeake Dr.		18e. ADDRESS			
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac & Respiratory Arrest</i>													
4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Coronary Artery Disease</i> (c) <i>Pneumonia</i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1-15, 19 81, to Present, that (I) (we) lost soul the deceased alive on 2-11, 19 81, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.													
22b. SIGNATURE <i>DR. J. LANZI</i>		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) DR. J. LANZI		22f. ADDRESS 721 BRIDGE ST ELKTON MD											
23a. BURIAL, CREMATION, REMOVAL SPECIES		23b. DATE FEB. 14 '81		23c. NAME OF CEMETERY OR CREMATORIAL ANGEL HILL CEM.			23d. LOCATION CITY OR TOWN HAIRE De GRACE		23e. COUNTY Harford		23f. STATE MD.		
24. FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME Mitchel Madison		ADDRESS HAIRE De GRACE			25a. DATE RECEIVED BY REGISTRAR Feb 17 1981		25b. REGISTRAR'S SIGNATURE						



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BALTIMORE, MARYLAND, 21201

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 04977		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- MATED	<input checked="" type="checkbox"/>	MONTH	DAY	YEAR	2b. HOUR			
PAUL			H.	LANE		2c. DATE PRONOUNCED DEAD	<input type="checkbox"/>	2	23	1981	M			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2d. DATE MONTH DAY YEAR	<input type="checkbox"/>	2	23	1981	2d. HOUR 9:15 AM			
male	white	2 28 24	56											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County							
TENN.		U.S.A.												
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TRUCK DRIVER		12b. KIND OF BUSINESS OR INDUSTRY							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) NC		13a. STATE NC		13b. COUNTY -		13c. CITY OR TOWN WINSTON SALEM		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 124 LOUVELLA LANE				
14. FATHER'S NAME CARL A.		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME RUTH		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES				
										16b. SOCIAL SECURITY NO. 412-28-5951				
								17. INFORMANT ANNE A. LANE		ADDRESS WINSTON SALEM NC				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal trauma DUE TO, OR AS A CONSEQUENCE OF 8120 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?		
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8:15 AM XX 2-23-1981			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Driver of tractor/tractor trailer collision									
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road			21f. LOCATION STREET 195			CITY OR TOWN Elkton		COUNTY Cecil		STATE Md.		
22a. I certify that I took charge of the remains described above, held an		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			and in my opinion									
death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/>														
ACTUAL SIGNATURE <i>[Signature]</i>		TITLE (SPECIFY) M.D. Assistant										DATE SIGNED 2-23-81		
EXAMINER'S NAME (TYPE OR PRINT)		Ann M. Dixon, M.D.			ADDRESS 111 Penn St.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 2-20-81		23c. NAME OF CEMETERY OR CREMATORIAL OAKLAWN			23d. LOCATION CITY OR TOWN WINSTON SALEM		COUNTY NC		STATE NC			
24. FUNERAL DIRECTOR NAME R.T. FOARD FUNERAL HOME		ADDRESS 100 ME		25a. DATE REC'D. BY REGISTRAR FEB 27 1981			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>							
BP														
DHMH - 17 (VR A15 ME (5))														
15M 2/80														

gullied, still 1891. 13. 25.

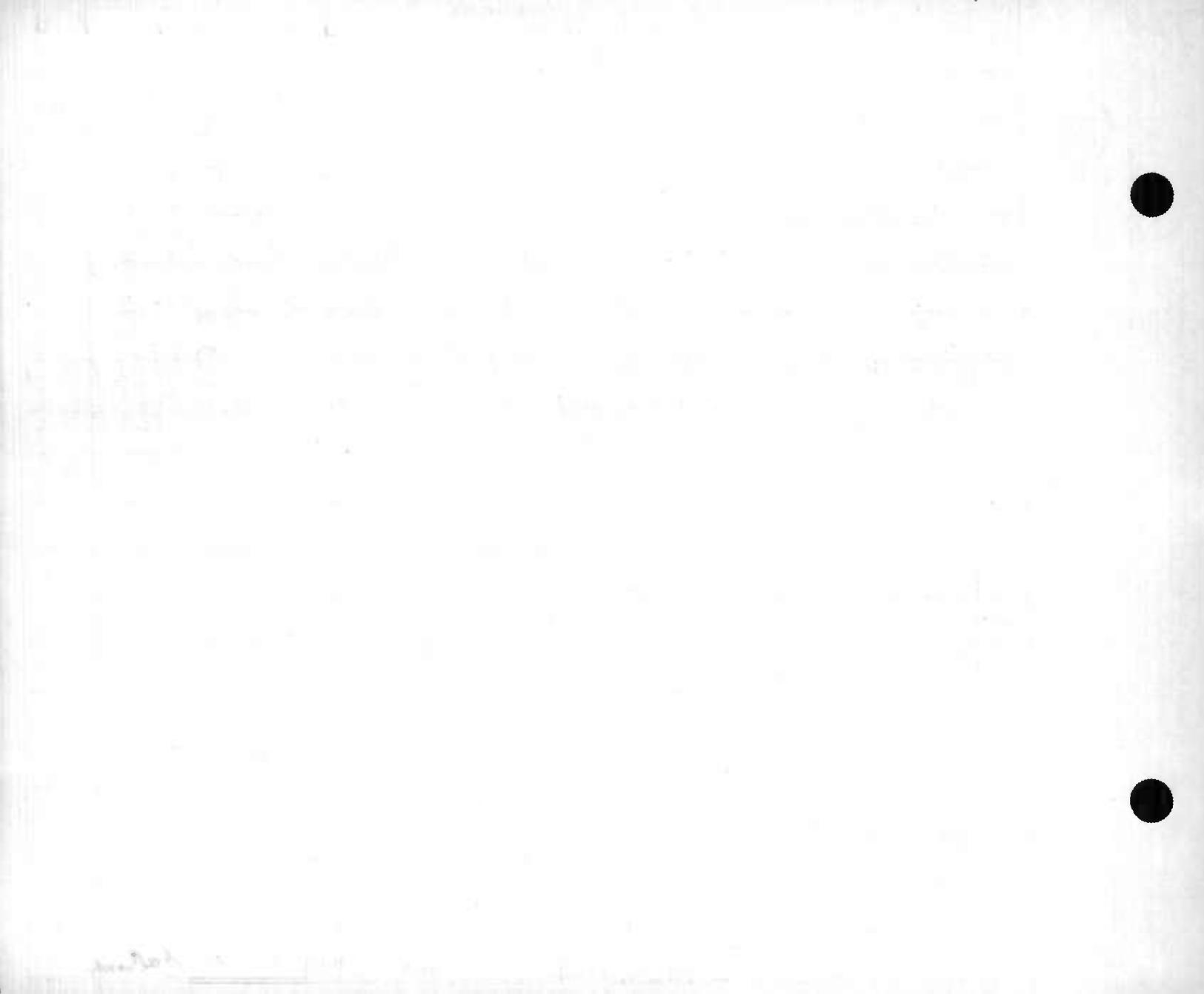
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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 0 4 9 7 8						
										REG. NO.						
1 - STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)							2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
			Helen W Mackey							2a. DATE OF DEATH		March 26 1981			5 30 A.M.	
3 SEX			4 RACE			5. DATE OF BIRTH MONTH DAY YEAR				6 AGE (IN YEARS LAST BIRTHDAY) 84 yrs			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
Fe			Cauc.			8 3 96										
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH			Cecil Co. MD.			
Penns.			U.S.A.													
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Elkton			Laurelwood Nsg. Center							Retired Nurse			Nursing			
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			403 Maryland Ave				
Md			Cecil		Elkton											
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							ADDRESS						
Joseph A. Wise			Ellen							Kenmore Apts. C-7 1950 City Ave Bala Cynwyd, Pa.						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
No			213-44-7834			Robert Mackey				4 hrs						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										Arteriosclerotic heart disease						
4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										DUE TO, OR AS A CONSEQUENCE OF (b) myocardial infarction						
{ DUE TO, OR AS A CONSEQUENCE OF (c)										4 hrs						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										cerebral vascular disease						
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from Oct. 19 50 to 2/26 19 81, that (I) (we) lost saw the deceased alive on 21 Dec 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE Edgar E. Folk III										DEGREE M.D.	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 2/26/81				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edgar E. Folk III, M.D.										22e. ADDRESS Union Hospital, Elkton, Md. 21921						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE March 2, 1981			23c. NAME OF CEMETERY OR CREMATORIAL Rosebank Cem. Calvert Cecil Md.				23d. LOCATION CITY OR TOWN COUNTY STATE						
Burial																
24. FUNERAL DIRECTOR NAME Gee Funeral Home, P.A. Elkton, Md.			25a. DATE REC'D. BY REGISTRAR MAR 5 1981							25b. REGISTRAR'S SIGNATURE Peter Holaday						



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8104979

REG. NO.

1 - STATE
REGISTRAR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner may be notified.

1. DECEASED NAME (TYPE OR PRINT)				FIRST <i>Catherine</i>	MIDDLE <i>Marie</i>	LAST <i>Maloney</i>	2a. DATE OF DEATH	MONTH <i>Feb.</i>	DAY <i>15</i>	YEAR <i>1896</i>	2b. HOUR <i>740 P.M.</i>				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil</i>								
10. CITY OR TOWN OF DEATH <i>Elkton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Union Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housekeeper</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>								
13a. STATE <i>Md.</i>				13b. COUNTY <i>Cecil</i>		13c. CITY OR TOWN <i>Elkton</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>1080 Frenchtown Road</i>					
14. FATHER'S NAME FIRST <i>James</i>				MIDDLE <i></i>		LAST <i>Maloney</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Ellen</i>		MIDDLE <i></i>		LAST <i>Gracey</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <i>215-32-1138</i>		17. INFORMANT <i>Elizabeth C. Maloney</i>		ADDRESS <i>1080 Frenchtown Rd.</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY				IMMEDIATE CAUSE (a) <i>Cardioglycemic arrest</i>											
				DUE TO, OR AS A CONSEQUENCE OF (b) <i>CHF chronic AF. H.H.D.</i>								Diabetes mellitus			
				DUE TO, OR AS A CONSEQUENCE OF (c) <i>CVA = left hemiplegia</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <i>19-77</i> to <i>1-22</i> , <i>19-81</i> , that <input type="checkbox"/> (we) last saw the deceased alive on <i>1-22</i> , <i>19-81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>H. W. Ob. M.D.</i>			22c. DEGREE <i></i>					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22d. DATE SIGNED <i>2-13-81</i>		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Hyung W. Ob. M.D.</i>			22f. ADDRESS <i>123 W. High St. Elkton, Md. 21921</i>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>2-16-81</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Immaculate Conception</i>			23d. LOCATION CITY OR TOWN <i>Cherry Hill</i>		23e. COUNTY <i>Cecil</i>			STATE <i>Md.</i>		
24. FUNERAL DIRECTOR NAME <i>Joe L. Lee</i>			24b. FEE PAID FUNERAL HOME ADDRESS <i>P.O. Box 1000 Elkton, Md.</i>					25a. DATE REC'D. BY REGISTRAR <i>FEB 17 1981</i>		25b. REGISTRAR'S SIGNATURE <i>John Murray</i>					

BP _____

DHMH-16 25M
(VRA 15, 4) 1/79

3
M

MARYLAND STATE DEPARTMENT OF HEALTH

81 04980

FOR STATE
HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201
 TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours
 after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18, give pages 1, 2,
 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form BM-1700
 to be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health
 prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN <input type="checkbox"/> Month Day Year OF ESTI- DEATH MATED February 14 1981	2b. HOUR 12:30	
Nancy	Louise	Meadows						
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (In years last birthday) 94 yrs.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	HOURS	MIN	
Female	White	October 28, 1886						
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Cecil		
Virginia		U.S.A.						
10. CITY OR TOWN OF DEATH Rising Sun			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 524 Telegraph Road			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homeswife		
						12b. KIND OF BUSINESS OR INDUSTRY Retired		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13c. CITY OR TOWN Cecil		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER same as above		
14. FATHER'S NAME James Horn			15. MOTHER'S MAIDEN NAME Sara		Middle Last Jackson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Harvey Meadows 491 Telegraph Rd. Rising Sun, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ASHD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic arteriolosclerosis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5-10 min. 10 years. 4								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Nine years								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Peter Stavros</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <i>PETER STAVRAKIS M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <i>2/14/81</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-17-81		23c. NAME OF CEMETERY OR CREMATORIAL West Nottingham Cemetery		23d. LOCATION (City or Town) Colona Cecil Maryland		
24. FUNERAL DIRECTOR <i>John Muller</i>		ADDRESS Rising Sun, Maryland		25a. READ BY REGISTRAR FEB 19 1981		25b. REGISTRAR'S SIGNATURE <i>John Muller</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 4 9 8 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
<i>Patricia C. Mears</i>						<i>2/2/81</i>				<i>950 P.M.</i>
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		# UNDER 1 YEAR		# UNDER 24 HRS
<i>Female</i>		<i>White</i>		<i>Month April 30, 1926 Year</i>		<i>54</i>		<i>MONTHS DAYS</i>		<i>YEARS</i>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.		
<i>Maryland</i>		<i>U.S.A.</i>				<i>Cecil County</i>				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
<i>Elkton</i>		<i>Union Hospital of Cecil County</i>				<i>Reg. Nurse</i>		<i>Nursing</i>		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		
<i>Delaware</i>		<i>New Castle</i>		<i>Middletown</i>		<i>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></i>		<i>215 North Cass Street</i>		
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME		ADDRESS				
<i>William</i>		<i>Earle</i>		<i>Mildred</i>		<i>Beta.</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
<i>No</i>		<i>222-14-7595</i>		<i>Mr. Groome Mears, Jr.</i>		<i>215 N. Cass St., Middletown,</i>				
18. CAUSE OF DEATH (Enter only one cause per line for 1(a), 1(b), and 1(c).) PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <i>Hypertension.</i>										
DUE TO, OR AS A CONSEQUENCE OF (b) _____										
DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) (this hospital) attended the deceased from <i>1/27</i> , 19 <i>87</i> , to <i>2/2</i> , 19 <i>87</i> , that (1) (we) last saw the deceased alive on <i>2/2</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Kenneth Lewis, MD</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>2/4/81</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>KENNETH LEWIS, MD</i>		22e. ADDRESS <i>12 Pennington St, Middletown, Del</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>Burial Feb. 5, 1981</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Forest Cemetery</i>		23d. LOCATION CITY OR TOWN <i>Middletown, New Castle, Delaware</i>		COUNTY STATE		
24. FUNERAL DIRECTOR NAME <i>Gee Funeral Home</i>		ADDRESS <i>259 E. Main St. Elkton, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>Feb 6, 1981</i>		25b. REGISTRAR'S SIGNATURE				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8104982			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
EDISON			L.	MERRILL		Feb 27, 1981				3:00 PM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.			
Male		White		May 21, 1894		86 yrs							
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		10. CITIZEN OF WHAT COUNTRY?		11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12. BALTIMORE CITY OR COUNTY OF DEATH		MD.					
Maryland		USA				Cecil							
13. CITY OR TOWN OF DEATH		14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				16. KIND OF BUSINESS OR INDUSTRY			
Elkton		Union Hospital				Farmer				Farming			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS								
Maryland	Cecil	Elkton			1552 Elkton Road								
14a. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST						
William		H.	Merrill, Sr.	Sallie		C.	Mills						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No		220-34-7078		Mrs. Lenna M. Merrill, Elkton, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Colon Surgery</i> { DUE TO, OR AS A CONSEQUENCE OF (c) <i>Myocardial Insufficiency</i> { DUE TO, OR AS A CONSEQUENCE OF										70 days 18 days			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION 2/9/81		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>CARCINOMA, colon</i>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>Feb 8, 1981</i>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <i>Feb 27, 1981</i> to <i>Feb 27, 1981</i> , that (I) (we) last saw the deceased alive on <i>Feb 27, 1981</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (not) (see) the body after death.										22c. DATE SIGNED 2/27/81			
22b. SIGNATURE <i>John A. Fischer, M.D.</i>		22c. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John A. Fischer</i>		22e. ADDRESS <i>166 W. 07 Ave, Elkton, MD</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/2/81		23c. NAME OF CEMETERY OR CREMATORIAL GILPIN MANOR MEMORIAL PARK, ELKTON, MD.		23d. LOCATION CITY OR TOWN COUNTY STATE							
24. FUNERAL DIRECTOR NAME HICKS HOME for FUNERALS, ELKTON, MD.		ADDRESS		25. DATE REC'D. BY REGISTRAR 3-1-81		25b. REGISTRAR'S SIGNATURE							

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	1	0	4	9	8	3
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH									MONTH	DAY	YEAR	2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	February 15, 1981									8:20p M			
WILLIAM			B.		MEYER													
3. SEX MALE			4. RACE WHITE		5. DATE OF BIRTH MONTH AUG. 5, 1920 DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 60			IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS DAYS HOURS MIN						
7a. BIRTHPLACE COUNTRY MARYLAND			7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CECIL COUNTY											
10. CITY OR TOWN OF DEATH PERRYVILLE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center Perry Point, Md.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER			12b. KIND OF BUSINESS OR INDUSTRY LUMBER YARD										
13a. STATE MARYLAND			13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 7008 WALLIS AVE. #21215										
14. FATHER'S NAME HERMAN			MIDDLE	LAST MEYER	15. MOTHER'S MAIDEN NAME ETTA													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. WWII-A.F.		17. INFORMANT MR. SIDNEY MEYER 7008 WALLIS AVE. BALTO., MD 21215													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>4100</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
DUE TO, OR AS A CONSEQUENCE OF (b)																		
DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. LOCATION STREET				CITY OR TOWN		COUNTY	STATE				
21e. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21g. DATE SIGNED													
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 3-29, 19 71, to 2-15, 19 81, that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 2-15, 19 81, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.												22b. SIGNATURE <u>Manut Atay</u>						
22c. DEGREE												ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input checked="" type="checkbox"/>	22d. DATE SIGNED 2-15-81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS VAMC PERRY POINT, MD.															
MANUT ATAY, M.D.																		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 2/16/81		23c. NAME OF CEMETERY OR CREMATORIAL BAII ISRAEL		23d. LOCATION CITY OR TOWN BALTIMORE		COUNTY		STATE							
24. FUNERAL DIRECTOR NAME Levinson & Son Funeral Home, Baltimore, Md.			25a. DATE REC'D. BY REGISTRAR FEB 18 1981									25b. REGISTRAR'S SIGNATURE <u>Atay</u>						
DHMH - 16 50M 7/77 (VR A 15 (4))																		

0058

1905 25 minutes

1000

VALLEY

1000 miles from center of valley AV

0000-0000

no significant differences found

18

CL

5

CL

CL

5

10-51-2

12

0000 1000 1000 0000

0000 0000 0000

undescript

1905 8 1837

no film taken because it was a nonived

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES.

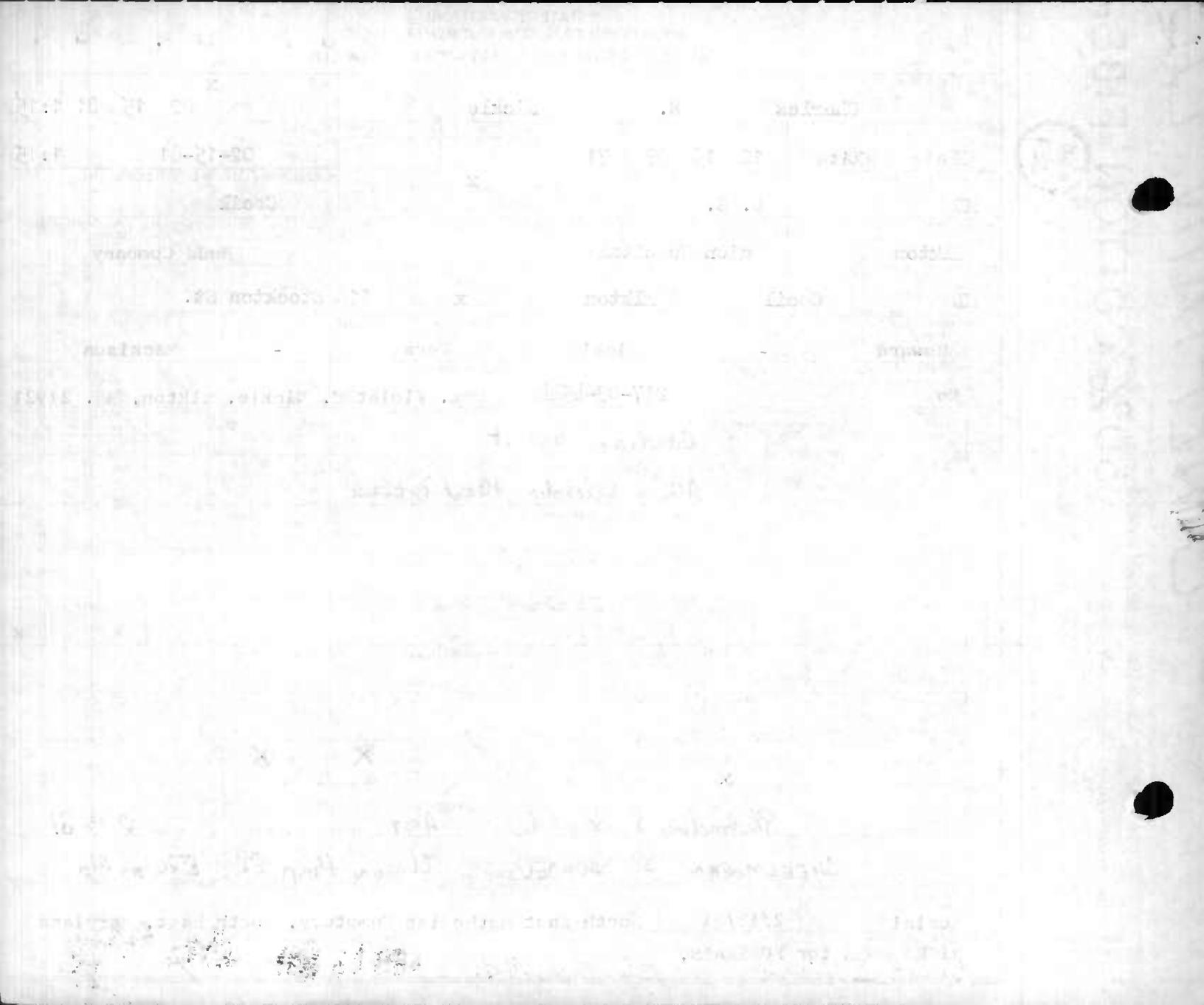
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 5104484

1- STATE REGISTRAR			2a. DATE KNOWN <input checked="" type="checkbox"/> MONTH 02 DAY 15 YEAR 1981 2b. HOUR 1:15P																	
I. DECEASED NAME FIRST Charles S. Nickle MIDDLE LAST			5. DATE OF BIRTH MONTH 12 DAY 15 YEAR 09			6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.			IF UNDER 1 YR. MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.			7c. DATE PRONOUNCED DEAD 02-15-81 19					
3. SEX Male			4. RACE White															2d. HOUR 1:15P		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD			7b. CITIZEN OF WHAT COUNTRY? U. S.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Cecil											
10. CITY OR TOWN OF DEATH Elkton			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Union Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY Budd Company											
13a. STATE MD			13b. COUNTY Cecil			13c. CITY OR TOWN Elkton			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 118 Stockton St.								
14. FATHER'S NAME FIRST Howard MIDDLE - LAST Nickle			15. MOTHER'S MAIDEN NAME FIRST Vera MIDDLE - LAST Mackison																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 217-09-4544			17. INFORMANT Mrs. Violet C. Nickle, Elkton, Md. 21921														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4140 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Atherosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?														
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE														
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																				
ACTUAL SIGNATURE Sheelmoan S. Sachdev, M.D.			TITLE (SPECIFY) Asst			MEDICAL EXAMINER			DATE SIGNED 2.15.81											
EXAMINER'S NAME (TYPE OR PRINT) SHEELMOAN S. SACHDEV			ADDRESS UNION Hosp. ER. Elkton Md																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2/18/81			23c. NAME OF CEMETERY OR CREMATORIAL North East Methodist Cemetery			23d. LOCATION CITY OR TOWN North East, Maryland			COUNTY STATE								
24. FUNERAL DIRECTOR NICKS HOME for FUNERALS, Ralph C. Nickle			25a. DATE REC'D. BY REGISTRAR FEB 19 1981			25b. REGISTRAR'S SIGNATURE														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

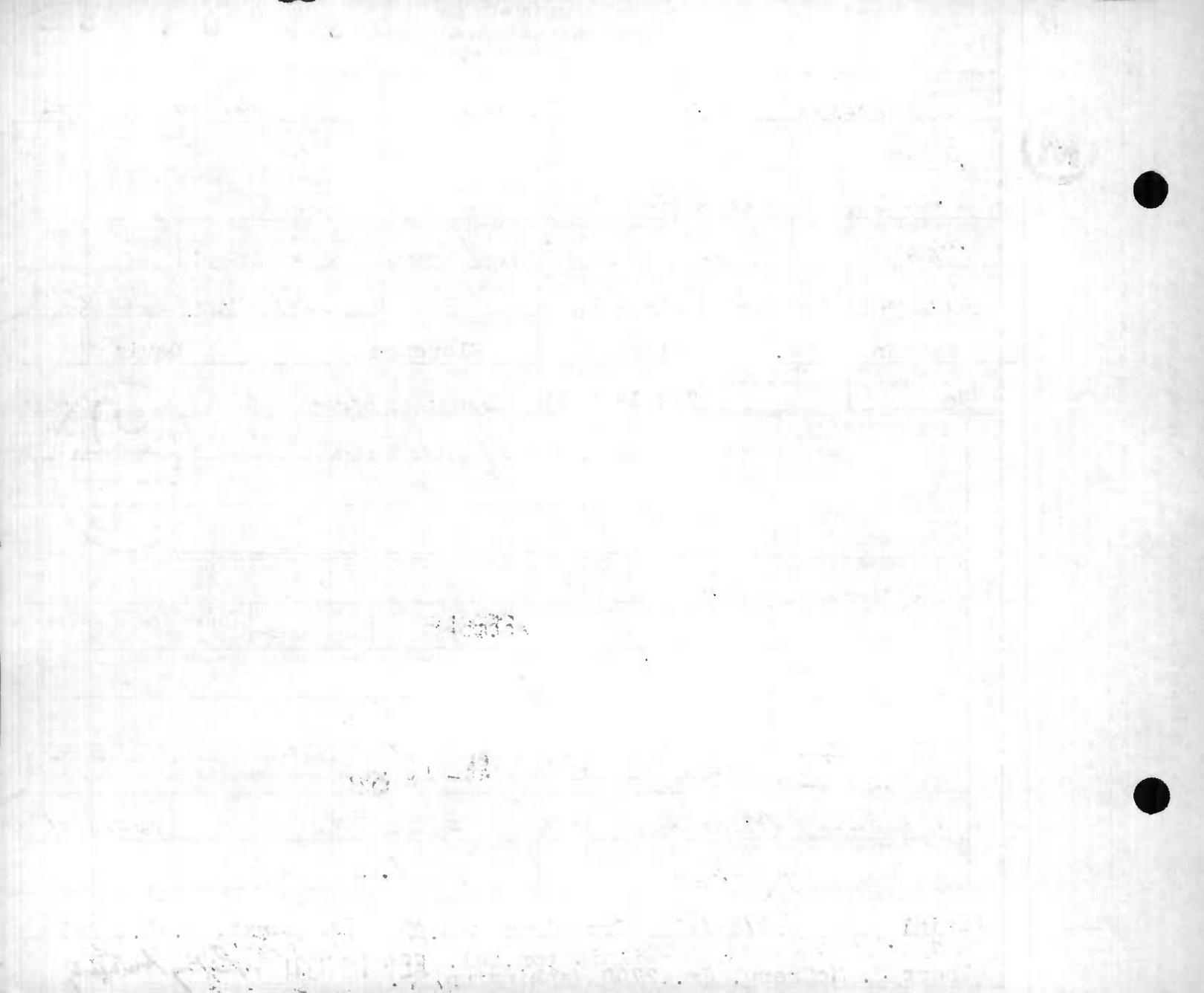
MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Thelma			M		oldham	Feb 14	81		848	M	
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Female		white	Aug 7 1920			60			MONTHS	YEARS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS		
Maryland		USA				Cecil			MONTHS	HOURS MIN	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Elkton		Union Hosp of Cecil County			Homemaker						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Delaware		Newcastle		Wilmington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1501 Montgomery Rd			
14. FATHER'S NAME FIRST		MIDDLE	15. MOTHER'S MAIDEN NAME FIRST			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			17. INFORMANT ADDRESS		
Herman		A.	Florence			NO			Ernest oldham		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			18b. SOCIAL SECURITY NO.			18c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Acute coronary occlusion			219 14 1891			2 hours					
4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b)								
DUE TO, OR AS A CONSEQUENCE OF			DUE TO, OR AS A CONSEQUENCE OF								
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
Diabetes		Obesity									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (the hospital) attended the deceased from Aug 19 78 to 14 Feb 19 81, that (I) (we) last saw the deceased alive on 14 Feb 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Wallace Obenshain MD									DEGREE		
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									22c. DATE SIGNED 14 Feb 81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wallace Obenshain									22e. ADDRESS Cecilton, Md		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 2/18/81		23c. NAME OF CEMETERY OR CREMATORIAL Gracelawn Mem Pk			23d. LOCATION CITY OR TOWN Farnhurst, N. C., Del				
24. FUNERAL DIRECTOR Albert J. McCrery, Jr.		25a. DATE REC'D. BY REGISTRAR FEB 19 1981		25b. REGISTRAR'S SIGNATURE Larry Kelley							
Wilmington, Del.											
Albert J. McCrery, Jr., 2700 Washington											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	1	0	4	9	8	6
												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR						
MARY			A.		PATCHELL	2 - 21 - 81						6:45 A.M.						
3. SEX			4. RACE		5. DATE OF BIRTH			MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)							
Female			White		JULY 7, 1896						84	IF UNDER 1 YEAR	IF UNDER 24 HRS					
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED			<input type="checkbox"/>	NEVER MARRIED	<input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland			USA		WIDOWED			<input type="checkbox"/>	DIVORCED	<input type="checkbox"/>	Cecil							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Elkton			Union Hospital									Homemaker						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS												
Maryland	Cecil	Elkton	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			324 Fair Hill Drive												
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			MIDDLE	LAST	JAMISON							
			John	S.	Patchell	Anna			Laura									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS									
No			215-54-0186			Mrs. Phyllis P. Ritchie, Wilmington, Del.												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. { (b) (c)																		
DUE TO, OR AS A CONSEQUENCE OF Dise. Scler. Cardis Vas. Ds. Seizures - Demyelination																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE						
22a. I certify that (I) (this hospital) attended the deceased from 2/20/81 to 2/21/81, that (I) (we) last saw the deceased alive on 2/20/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS															
Ernesto M. Ablang, M.D.			200 Bow Street, Elkton, Maryland 21921															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY	STATE					
Burial			2/24/81			Sharps Cemetery			Fair Hill, Maryland									
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE									
Donald J. Hicks			HICKS HOME for FUNERALS, ELKTON, MD.			FEB 26 1981			D. J. Hicks									

1990.0

1990

48

69.1 5.00

adult

plumage

juv.

immature

immature

Ischnocnema rotundata

males

oviposition sites 48

X

oviposition

oviposition

oviposition

ovipositor

empty

open

closed

not

all abdominal segments visible - expels eggs

oh

X

2

I

1990.0 oviposition analysis - males - count of D0

0.0 - 100.0 - 200.0

0 100 200

0 100 200

0 100 200

0 100 200

length of abdomen to width of head

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8104987
										REG. NO.
1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Annie L. Peterson				Feb. 13, 1981				11:45 A		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
Female	White	June 9, 1897			83 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County			MD.		
10. CITY OR TOWN OF DEATH Rising Sun	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Manor Nursing Home	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home					
13a. STATE Del.	13b. COUNTY Newcastel	13c. CITY OR TOWN Newcastle	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 16 Morris Rd.				
14. FATHER'S NAME Andrew	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME Catherine			MIDDLE	LAST	Harkness		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. 171 24 6440	17. INFORMANT Son	ADDRESS F. Carlton Peterson, 16 Morris Rd.,			Newcastle, Del.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days	
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b) and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4392 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										5 yrs.
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic cardiovascular disease</u>										
DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE					
22a. I certify that (I) (this hospital) attended the deceased from 6-1, 1981, to 2-13, 1981, that (I) (we) last saw the deceased alive on 2-13, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Neil Taylor</u>	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 2-14-81					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Neil Taylor MD	22e. ADDRESS Haines St., Rising Sun, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 2/16/1981	23c. NAME OF CEMETERY OR CREMATORIAL Head of Christiana	23d. LOCATION CITY OR TOWN Newark, New Castle, Del.	23e. COUNTY New Castle, Del.	STATE					
24. FUNERAL DIRECTOR NAME Robert T. Jones Newark, Del.	ADDRESS	25a. DATE REC'D. BY REGISTRAR FEB 19 1981	25b. REGISTRAR'S SIGNATURE <u>Robert T. Jones</u>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it may be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 4 9 8 8

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)			FIRST <i>Mildred</i>	MIDDLE <i>A.</i>	LAST <i>Renshaw</i>	2a. DATE OF DEATH MONTH <i>Dec.</i> DAY <i>12</i> YEAR <i>1922</i>	MONTH YEAR	DAY	2b. HOUR IF UNDER 1 YEAR <i>58</i> YRS MONTHS DAYS HOURS MIN	IF UNDER 24 HRS HOURS MIN	
3 SEX <i>Female</i>		4 RACE <i>White</i>	5 DATE OF BIRTH MONTH <i>Dec.</i> DAY <i>12</i> YEAR <i>1922</i>			6. AGE (IN YEARS LAST BIRTHDAY) <i>58</i> YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>McEwensburg, Pa.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil</i> MD		
10 CITY OR TOWN OF DEATH <i>Elkton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Union Hospital</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Sales</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Garment</i>			
13a. STATE <i>Md.</i>		13b. COUNTY <i>Cecil</i>		13c. CITY OR TOWN <i>Elkton</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>100 Jarrow Road</i>			
14 FATHER'S NAME FIRST <i>Charles</i>		MIDDLE <i>O.</i>	LAST <i>Reed</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Stella</i>			MIDDLE			LAST <i>Boyer</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO <i>166-12-3952</i>			17 INFORMANT <i>Wayne E. Renshaw</i>			ADDRESS <i>100 Jarrow Rd., Elkton, Md.</i>			
18 CAUSE OF DEATH (Enter only one cause per line for 1(a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Hepatic Failure</i> DUE TO, OR AS A CONSEQUENCE OF 1550 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hepatoma</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) (we) attended the deceased from <i>2/5</i> to <i>2/5</i> , 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>2/5</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Yogish A. Patel</i>		22c. DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>2/6/81</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Yogish A. Patel, MD</i>		22e. ADDRESS <i>NEWARK Del</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>2/10/81</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Gilpin Manor Mem. Pk.</i>			23d. LOCATION CITY OR TOWN <i>Elkton</i>			
24. FUNERAL DIRECTOR NAME <i>UNIVERSAL HOME C.R.A.</i>		ADDRESS <i>Elkton, Md.</i>			25a. DATE REC'D. BY REGISTRAR <i>FEB 11 1981</i>			25b. REGISTRAR'S SIGNATURE <i>John C. Murphy</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8104989		
												REG. NO.		
1. FOR STATE REGISTRAR			I. DECEASED NAME			LAST			2a. DATE OF DEATH			1b. HOUR		
(TYPE OR PRINT)			John R. Slaten						February 6, 1981			8 P. M.		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male		White		Month Day Year July 11, 1915			65 YRS			MONTHS DAYS		HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
Illinois		USA					Cecil							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Elkton			38 Hillcrest Court						Printer- Owner			C. & L. Printing		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS				
Maryland			Cecil		Elkton					38 Hillcrest Court				
14. FATHER'S NAME			MIDDLE		LAST		15. MOTHER'S MAIDEN NAME			MIDDLE		LAST		
John			-		Slaten		Fleta			E.		Berry		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. IF YES, GIVE WAR OR DATES		16c. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS			
Yes			WW 2		317-03-3136			Mrs. Ruth P. Slaten, Elkton, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												Hepatic Failure		
DUE TO, OR AS A CONSEQUENCE OF (b)												Colon Carcinoma		
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR XXXXXX XXXX XXXX XXXX			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>80</u> , to <u>Nov</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>Nov</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <u>Yogish A. Patel</u>			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 2/6/81					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Yogish A. Patel, M.D.			22e. ADDRESS 179 W. Chestnut Hill Rd. Newark, Del.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2/9/81			23c. NAME OF CEMETERY OR CREMATORIAL Rosebank Cemetery			23d. LOCATION CITY OR TOWN Calvert,			COUNTY STATE Cecil, Maryland		
24. FUNERAL DIRECTOR NAME HICKS HOME FOR FUNERALS, ELKTON, MD.						25a. DATE REC'D. BY REGISTRAR FEB 11 1981			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

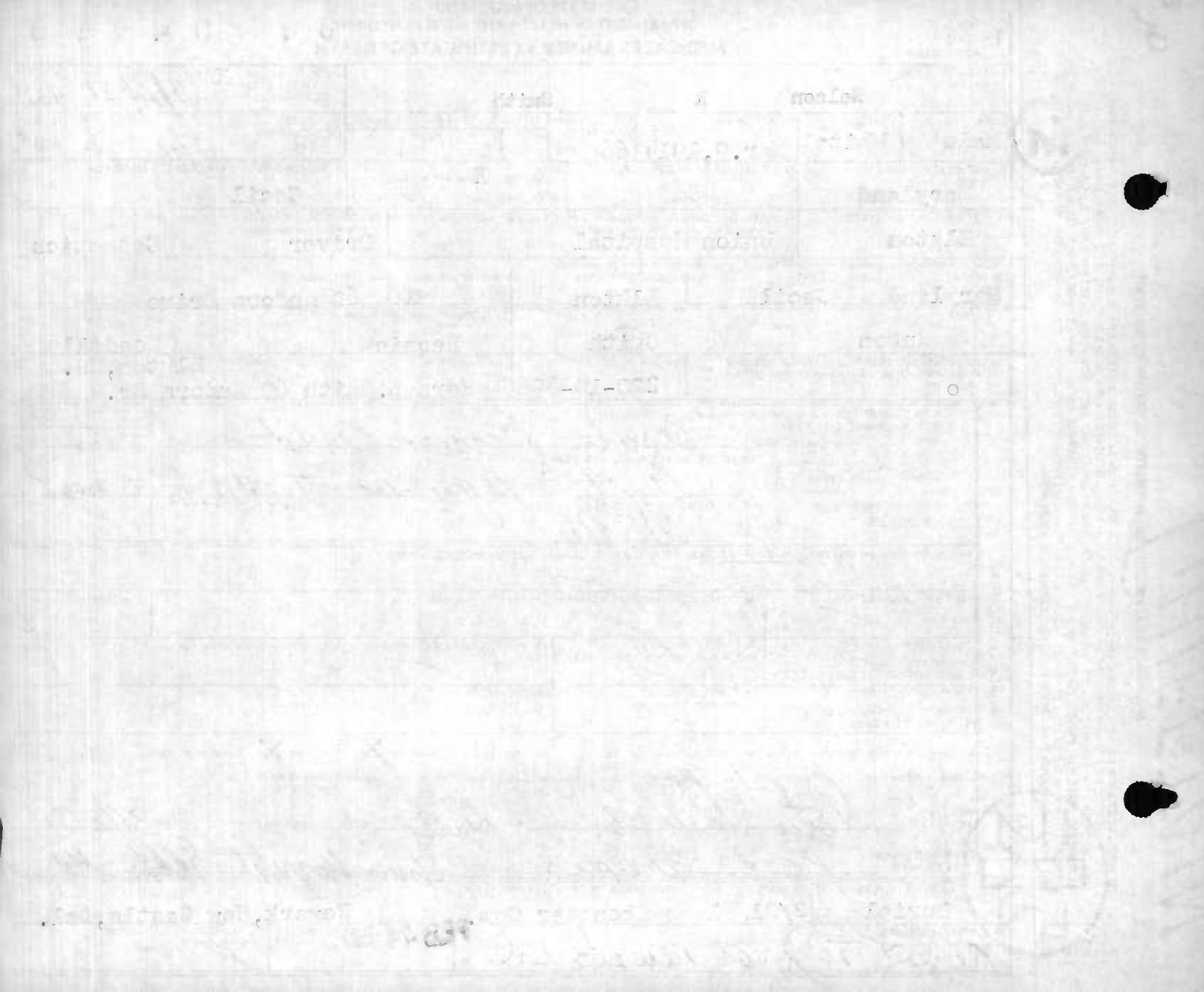
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 04990	
1 - STATE REGISTRAR			I. DECEASED NAME FIRST MIDDLE LAST						2a. DATE KNOWN TO MONTH DAY YEAR OF ESTIMATE <input type="checkbox"/> DEATH MATED <input checked="" type="checkbox"/> 2/18/81			2b. HOUR 4:22 M	
Nelson R Smith													
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Mar. 9, 1914 66		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2/18 1981			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA						B MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Cecil	
10. CITY OR TOWN OF DEATH Elkton			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Driver			12b. KIND OF BUSINESS OR INDUSTRY Cosmetics	
13a. STATE Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 60 Andora Drive			MD.		
14. FATHER'S NAME FIRST Ruben			MIDDLE Smith			15. MOTHER'S MAIDEN NAME FIRST Bessie			LAST Kendall				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 220-10-8965			17. INFORMANT Fern L. Smith			ADDRESS Elkton, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Cardiac Arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>Acute Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF <i>ASD</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min?	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Peter Starbuck</i>			TITLE (SPECIFY) M.D. <i>Deputy</i>			MEDICAL EXAMINER			DATE SIGNED 3/18/81				
EXAMINER'S NAME (TYPE OR PRINT) PETER STARBUCK			ADDRESS Union Hospital			LOCATION CITY OR TOWN Newark, New Castle, Del.			COUNTY STATE				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2/21/81			23c. NAME OF CEMETERY OR CREMATORIAL Ebenezer Cem.			23d. LOCATION CITY OR TOWN Newark, New Castle, Del.				
24. FUNERAL DIRECTOR NAME Robert T. Jones			ADDRESS Newark, Del.			25a. DATE REC'D. BY REGISTRAR 2/21/81			25b. REGISTRAR'S SIGNATURE <i>Robert T. Jones</i>				
DHMH - 17 (VR A15 ME (5))													
15M 7/77													



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be detached for use at the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 1 0 4 9 9 1	
												REG. NO.	
1 - FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR			2b. HOUR 7:18A M	
John V. Szamborski									February 16, 1981				
3. SEX Male			4 RACE White			5 DATE OF BIRTH MONTH DAY YEAR 9 16 1914			6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.			# UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania			7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Cecil			MD.	
10 CITY OR TOWN OF DEATH Perry Point			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VAMC			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Postal Clerk/Ret.			12b. KIND OF BUSINESS OR INDUSTRY Post Office				
13a. STATE Maryland			13b. COUNTY Harford			13c. CITY OR TOWN Aberdeen			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 1 Defense Drive	
14. FATHER'S NAME FIRST Walter			MIDDLE Szamborski			15. MOTHER'S MAIDEN NAME FIRST Mary			LAST Slywinski				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1950 - 1952			16c. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5715			17. INFORMANT VAMC, Perry Point, Maryland			ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis, ascites												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b)			DUE TO, OR AS A CONSEQUENCE OF							
			(c)			DUE TO, OR AS A CONSEQUENCE OF							
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 12-25- 1980 , to 2-16- 1981 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 2-16- 1981 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death.													
22b. SIGNATURE <i>niranjan</i>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 2-16-81				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) NIRANJANA J. SHAR, M.D.			22e. ADDRESS VAMC, Perry Point, Maryland										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2/21/1981			23c. NAME OF CEMETERY OR CREMATORIAL Harford Mem. Gardens			23d. LOCATION CITY OR TOWN Aberdeen, R.D., Harford Md.			COUNTY	STATE
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, Md. 21001			ADDRESS 21001			25a. DATE REC'D. BY REGISTRAR FEB 23 1981			25b. REGISTRAR'S SIGNATURE <i>photograph</i>				

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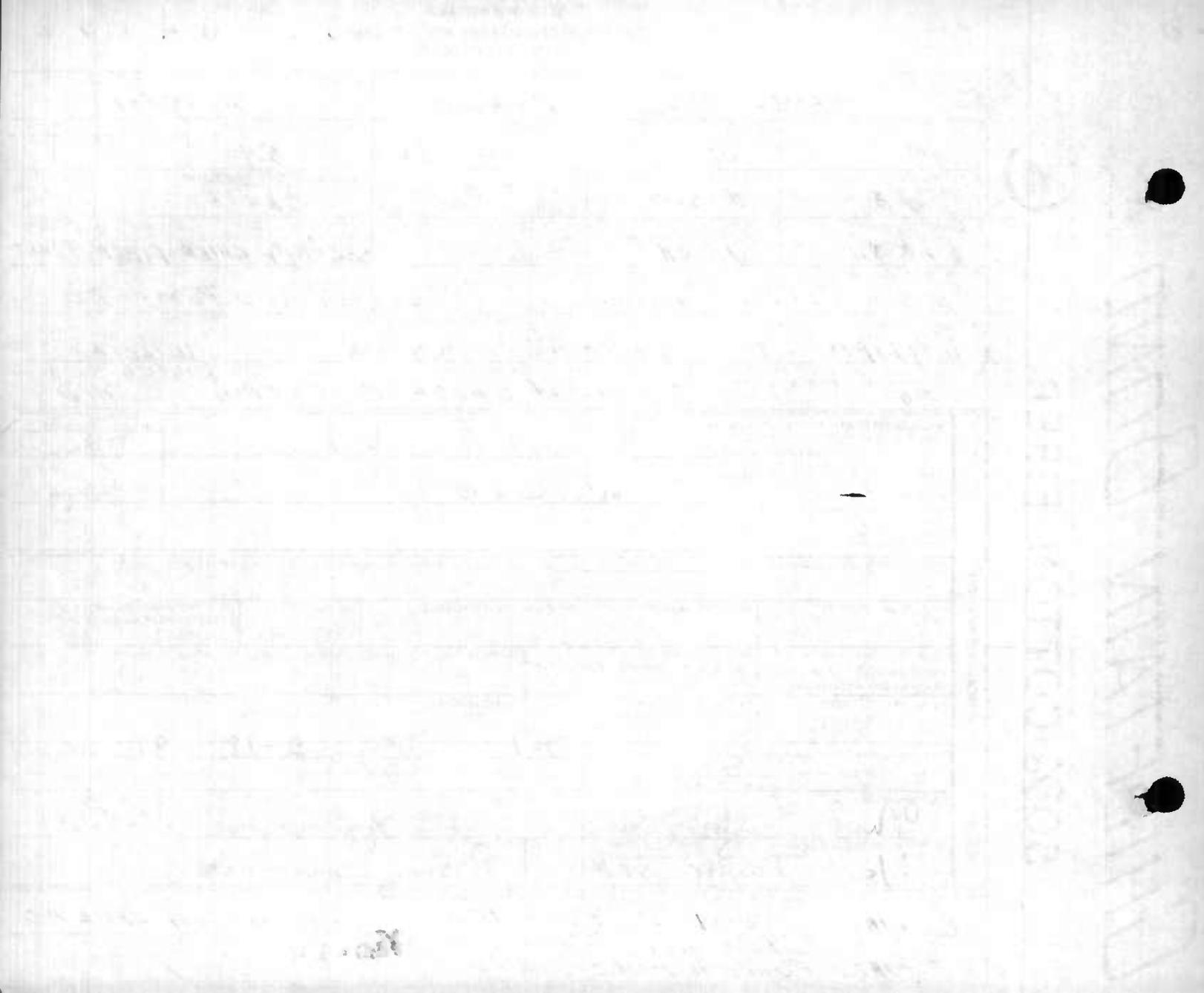
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial/cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8104992 CERTIFICATE OF DEATH													
REG. NO.													
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
JAMES L. VERNON						2-18-81							
3. SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
M		W		1 8 22			59 yrs						
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
VA		U.S.A.					CECIL						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
ELKTON		UNION										SECURITY CHIEF	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			
MD		CECIL		RISING SUN						89 RED PUMP RD			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										12b. KIND OF BUSINESS OR INDUSTRY	
WILLIAM T. VERNON		RHODA C. VERNON										FIBER PLANT	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 220-14-1664		17. INFORMANT ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
				RHODA C. VERNON			7 days 5 yrs.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) AS.C.R.O. DUE TO, OR AS A CONSEQUENCE OF (c).													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7-1, 1979, to 2-18, 1981, that (I) (we) last saw the deceased alive on 8-18, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Neil Taylor J&MO		DEGREE											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Neil Taylor J&MO		22e. ADDRESS Rising Sun, Md.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22f. DATE SIGNED 2-20-81		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2-20-81		23c. NAME OF CEMETERY OR CREMATORIUM BROOKVIEW			23d. LOCATION CITY OR TOWN RISING SUN, CECIL MD		COUNTY CECIL MD		STATE MD		
24. FUNERAL DIRECTOR NAME R.T. FORD FUNERAL HOME		ADDRESS RISING SUN MD			25a. FEE PAID BY REGISTRAR \$564.00		25b. REGISTRAR'S SIGNATURE						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8104993		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2. DATE OF DEATH			MONTH	DAY	YEAR	7b. HOUR		
CHARLES F. WARD, Sr.					WARD, Sr.	February 16, 1981						5:45 P.M.		
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
Male			White		JUNE 25, 1908			72			MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Charlestown, Md.			U.S.A.						Cecil					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Elkton			Union Hospital			Operator			Elkton Corp.					
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS				
Md.			Cecil		Elkton		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			299 Hollingsworth Manor				
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			LAST					
			John	L.	Ward	Mary			Calvert					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS					
yes			218-01-8197			Elizabeth A. Ward			Elkton, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <i>Cardio - Respiratory Failure</i>														
4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last														
DUE TO, OR AS A CONSEQUENCE OF (b) <i>COPD - Pul. Disease</i>														
DUE TO, OR AS A CONSEQUENCE OF (c) <i>HSCVD & Pneumonia</i>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN					
									COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Jan. 21, 1981, to Feb. 16, 1981, that (I) (we) last saw the deceased alive on 2/16/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death												22c. DATE SIGNED		
22b. SIGNATURE <i>Ernesto M. Ablang</i> DEGREE												22c. DATE SIGNED		
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>												22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS											
Ernesto M. Ablang, M.D.			200 Bow Street Elkton, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2-20-81			23c. NAME OF CEMETERY OR CREMATORIALy			23d. LOCATION CITY OR TOWN					
						St. John's Cemetery			Charlestown Cecil Md.					
24. FUNERAL DIRECTOR NAME <i>Edward M. McKeon</i>			ADDRESS <i>P.A.</i>			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
						FEB 23 1981			<i>Anthony Melody</i>					

1000 ft - 1
Crested - skunk
and 69 = 7015
in winter - 6824

1000 ft - 1
Crested - skunk
and 69 = 7015
in winter - 6824

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	21. HOUR	
<i>Thelma M. Winterborne</i>							2	1	81		4 AM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		# UNDER 1 YEAR		# UNDER 24 HRS	
<i>Fe</i>		<i>Cauc.</i>		MONTH <i>04</i>	DAY <i>02</i>	YEAR <i>95</i>	<i>85</i>	YEARS	MONTHS	DAYS	HOURS MIN	
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				<i>Cecil Co.</i>	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
<i>Eikton</i>		<i>Laurelwood Nursing Center</i>					<i>Clerical</i>					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS				
<i>Del.</i>		<i>New Castle</i>		<i>Newark</i>				<i>726 Papermill Rd. Wilm, Del.</i>				
14. FATHER'S NAME		FIRST <i>Lincoln</i>	MIDDLE	LAST <i>Masner</i>	15. MOTHER'S MAIDEN NAME			FIRST <i>Mary</i>	MIDDLE	LAST <i>Paul</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT			ADDRESS					
<i>No</i>		<i>178-18-0037</i>		<i>Mrs. Hazel Godwin</i>			<i>726 Papermill Rd, Newark Del.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) <i>Cerebro & Reep Cerv.</i>												
DUE TO, OR AS A CONSEQUENCE OF (b) <i>-Cerebral Cervical Disease</i>												
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Asphyx</i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
							YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept 30, 1981</i> to <i>1-31, 1981</i> , that (we) lost sow the deceased alive on <i>1-31, 1981</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.												
22b. SIGNATURE <i>J. G. Lanzi</i>		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>2/2/1981</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Joseph G. Lanzi, M.D.</i>		22e. ADDRESS <i>Elkton Medical Park, Elkton, Md 21921</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>2/4/81</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Ebenezer</i>			23d. LOCATION CITY OR TOWN <i>Newark, New Castle, Del.</i>		23e. COUNTY <i>New Castle, Del.</i>		STATE	
24. FUNERAL DIRECTOR <i>Robert T. Jones</i>		ADDRESS <i>Newark, Del.</i>			25a. DATE REC'D. BY REGISTRAR <i>FEB 10 1981</i>			25b. REGISTRAR'S SIGNATURE <i>Robert T. Jones</i>				

